centers for medicare & medicald services

STATEMENT OF (X1) DEFICIENCIES PROVIDER/SUPPLIER/CLIA 365022			(x2) multiple construction a. building b. wing		(X3) DATE SURVEY COMPLETED 10/10/2018			
	der of supplier Y CENYER FOR REHABILITA	TION AND HEALING	xenia oh, 45385					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEFRECEDED BY FULL		ID PREFIX TAG	BE NATE	COMPLETIO N			
F 0000	OH00100158. ADMINISTRATOR: CERTIFIED BED C. CENSUS: 77 MEDICARE: 7 MEDICAID: 40 OTHER: 30	TIGATION NT NUMBER OMPLAINT NUMBER Kayla Bartoli. #7146 APACITY: 99	F 0000					
	ector's or provider/supplier re			tibe		(x6) date		

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. for nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility, if deficiencies are cited, an approved plan of correction is requisite to continued program participation.

11/02/2018

STATEMENT O		(X1) PROVIDER/SUPPLIER/CLIA 365022			(x2) multiple construction (X3) DATE SUR COMPLETE a. building 10/10/				
	der or supplier Y CENYER FOR REHABILITA	TION AND HEALING		street address, city, state, zip code 1301 NORTH MONROE DRIVE XENIA ON, 45385					
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F 0607 F 0607 SS=D	implement written pot that: §483.12(b)(1) Prohit neglect, and exploits misappropriation of §483.12(b)(2) Estab procedures to invest allegations, and §483.12(b)(3) Include at paragraph §483.5 This STANDARD is by: Based on clinical rean employee file, st facility self reported policy review, the faimplement the abus immediately reporting and suspend staff firmistreatment/negle which resulted in a This affected one (for accidents. The SRI's in the past the census was 77. Findings include:	elop/Implement fies fity must develop and fillcies and procedures fit and prevent abuse, ation of residents and resident property, lish policies and tigate any such figure an	F 06		On 10-11-2018, RNs, LPNs, STNAs, Son Services, Dietary, Housekeeping, Maintainence and Administrative staff we in-serviced by the Administrator on the Apolicy to ensure proper notification of an suspected abuse is communicated to the Administrator immediately. On 10-11-18, the Administrator was in-serviced by the VP of Operations on properly following the Abuse policy in reference to timely suspension of employees during an abust investigation. On 10/11/2018, all residents were interved by the Administrator/designee for abuse neglect and misappropriation with no inclindings. Residents with a Bims score received a head to toe assessment by the Don/designee on 10/11/2018 with result documented on the facilitie's shower should be added to the skin assessment completed Don/designee with results documented shower sheet. RV	ere Abuse by erviced bwing se liewed cidental 7 he ds eet. dom e, s. re a I by the	11/02/2018		

STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA a. building b. wing name of provider or supplier HOSPITALITY CENTER FOR REHABILITATION AND HEALING (x2) multiple construction a. building b. wing street address, city, state, zlp code 1301 NORTH MONROE DRIVE XENIA OH, 45385	(X3) DATE SURVEY COMPLETED 10/10/2018
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO N
F 0607 With diagnoses including Alzheimer's disease, hypertension, glaucoma and degenerative joint disease. Review of the Minimum Data Set (MDS) assessment dated 09/09/18 revealed the resident had severely impaired cognition, was totally dependent on two staff for transfers, did not ambulate and had no recent falls. Review of the resident's care plan revealed a mechanical lift (hoyer) was initiated on 12/01/16 for all transfers. Review of the "Resident Care Card" used by the staff revealed the resident was totally dependent on staff for hoyer transfers. Review of the progress note dated 09/22/18 at 12:42 P.M. revealed Licensed Practical Nurse (LPN) #99's was informed that while Resident #1 was transferred from her bed to her wheelchair, the resident's right leg was bent backwards and she sat on her leg. The physician was notified and ordered an X-ray of the leg. The resident's daughter who was her power of attorney (POA) and Registered Nurse (RN) #97 who was the former Director of Nursing (DON) were also notified. The X ray result revealed a right distal femur fracture and the resident went to the hospital the morning of 09/23/18. Review of the employee file for State Tested Nursing Assistant (STNA) #98 revealed she was hired on 07/20/16 and	

centers for medicare & medicald services

STATEMENT C DEFICIENCIES		(X1) PROVIOER/SUPPLIER/CLIA 365022	VIOER/SUPPLIER/CLIA		(x2) multiple construction a: building b. wing	COMPL	(X3) DATE SURVEY COMPLETED 10/10/2018	
name of provi	der or supplier Y CENTER FOR REHABILITA	tion and healing	street address, city, state, zip code 1301 NORTH MONROE DRIVE XENIA OH, 45385					
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F 0607	the time card for STI continued to work aft 09/22/18 until 7:19 F 09/23/18 from 7:08 A Review of STNA #98 the incident revealed resident to do a one from the bed to the vaccidentally sat the of her leg". Interview with the Ad 10/10/18 at 12:30 P at 11:30 A.M. STNA improper transfer by #1 without using the required. The Admin documentation that provided with mechathere should always hoyer lift on 09/24/1 Administrator identifithe licensed nursing provided with this transmitted with the fresulting in a femur was not reported to next day 09/23/18, suspended timely uron 09/23/18 at 7:07 staff training was not Administrator verification in the state potential mistreatments.	d standing. Review of NA #98 revealed she ter the incident on P.M. and also on A.M. to 7:07 P.M. B's statement related to d she "picked up the person pivot transfer wheelchair and resident down on top diministrator on M. verified on 09/22/18 #98 completed an herself with Resident mechanical lift as instrator provided inne of the staff were anical lift education that be two staff using the 8; however, the ied 18 STNAs and all staff that were not aining. The d the improper transfer fracture for the resident her timely until the STNA #98 was not ntil the end of her shift P.M., and the nursing	F 06	07				

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA 365022		-	(x2) multiple construction (X3) DATE SUF COMPLETI a. building b. wing (X3) DATE SUF		
name of provider or supplier HOSPITALITY CENTER FOR REHABILITA	ATION AND HEALING		street address, city, state, zip code 1301 NORTH MONROE DRIVE XENIA OH, 45386			
PREFIX (EACH DEFICICIES	MENT OF DEFICIENCIES ICY MUST BEPRECEDED Y FULL	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO N	
abuse policy following Review of facility Stincident involving Review of the policy and 01/01/16 revealed a knowledge of poter abuse, or neglect or responsible for report Administrator. The the concern to the shours and results of five days. The investing appropriate correct training. The staff versident from the deficiency is better the concern to the shours and results of the substantial of the staff versident from the staff versident from the deficiency is better the concern to the staff versident from the staff versident from the concern to the concern to the staff versident from the concern to the staff versident from the concern to the concer	raining related to the ng this incident. Ri's revealed the esident #1 on 09/22/18 y titled "Abuse:Abuse of Procedure" dated any person having stial mistreatment, if a resident was porting the incident to the Administrator reported state agency within 24 if the investigation within stigation included ive action such as staff was immediately the investigation to m further harm.	FOR	507			

STATEMENT OF (X1) DEFICIENCIES PROVIDER/SUPPLIER/CLIA 365022 name of provider or supplier		streel	(x2) multiple construction a. building b. wing (X3) DATE SURVEY COMPLETED 10/10/2011		ETED		
HOSPÍTALIT	y center for rehabilita`	TION AND HEALING			NORTH MONROE DRIVE (A OH, 45385		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETIO N
F 0609 F 0609 SS=D	reported immediately hours after the allegal events that cause the abuse or result in selection and do not result in state the allegation and do not result in state of the administrator other officials (included Survey Agency and services where state jurisdiction in long-teacordance with State established proceduments of the state of the designated representation of the State within 5 working day the alleged violation corrective action mu	orting of Alleged use to allegations of collation, or collity must: e that all alleged abuse, neglect, eatment, including source and resident property, are by but not later than 2 cation is made, if the e allegation involve arious bodily injury, or are if the events that do not involve abuse serious bodily injury, of the facility and to be law provides for form care facilities) in the law through res. If the results of all administrator or his or esentative and to other ce with State law, e Survey Agency, is of the incident, and if is verified appropriate	F 06	- 1	On 10-11-18, the Administrator was in-sety the VP of Operations on the Abuse pound State Reportable Incidents. All residents were interviewed for abuse, neglect and misappropriation by the Administrator on 10/11/2018 with no incidentings. Residents with a Bims score < 7 received a head to toe assessment with a documented on the facility shower sheet no incidental findings. The Administrator reported the incident involving resident #11/1/2018. All potential reportable incidents will be reviewed immediately by the Administrat Regional Clinical Nurse. All reportable incidents will be submitted per CMS guidelines. All incidents will be reviewed by the Administrator and Director of Nursing da determine if it is a reportable incident and follow guidelines to appropriately report incident. The process will be ongoing an tracked on the incident log.	dental results with or and ily to d	11/02/2018

Event:YCVX11

centers for medicare & medicald services

STATEMENT OF (X1) DEFICIENCIES PROVIDER/SUPPLIER/CLIA 365022 Bame of provider or supplier				(x2) multiple construction a. building b. wing address, city, state, zip code	(X3) DATE S COMPLE 10/1		
HOSPITALIT	y center for rehabilita	TION AND HEALING			NORTH MONROE DRIVE A OH, 45385		
(X4) ID PREFIX TAG	(EACH DEFICICIENC	ENT OF DEFICIENCIES LY MUST BEPRECEDED FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETIO N
F 0609	unsafe transfer by st right femur fracture. out of three resident accidents. The facil SRI's in the past three census was 77. Findings include: Review of the medic #1 revealed the resident had severe was totally dependent transfers, did not an recent falls. Review of the "Resiby the staff revealed totally dependent of transfers. Review of the progression of the progression of the progression of the progression.	cord review, staff acility self reported is policy review, the adiately report int/neglect to the agency following an aff which resulted in a This affected one (#1) is reviewed for ty identified three are months. Facility and record for Resident dent was admitted as include Alzheimer's on, glaucoma and sease. aum Data Set (MDS) 19/09/18 revealed the by impaired cognition, int on two staff for inbulate and had no of the resident's care chanical lift (Hoyer) was of or all transfers. dent Care Card" used of the resident was in staff for Hoyer	F 060	99			
	USIZZI 10 at 12.42 P	JVI. 16VGAICO LICONSCO		***************************************			

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STATEMENT (DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA 365022			a, building			(X3) DATE : COMPL 10/:	
name of provider or supplier HOSPITALITY CENTER FOR REHABILITATION AND HEALING Street address, city, state, zip code 1301 NORTH MONROE DRIVE XENIA OH, 45385									
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F 0609	that while Resident # from her bed to her wand she sat on her le notified and ordered. The resident's daugh of attorney (POA) and (RN) #97 who was the Nursing (DON) were ray result revealed a fracture and the residents with the Act 10/10/18 at 12:30 P. at 11:30 A.M. STNA improper transfer by in a femur fracture for reported to her timel 09/23/18. The Admir incident was not repagency as a SRI for that resulted in a fractional fraction of the subsection of the	I) #99's was informed fit was transferred wheelchair, the as bent backwards ag. The physician was an X-ray of the leg. Inter who was her power in the former Director of also notified. The X right distal femur dent went to the of 09/23/18. Idministrator on M. verified on 09/22/18 #98 completed an herself which resulted for the resident was not by until the next day inistrator verified the orted to the state potential mistreatment curre for Resident #1 aff training related to owing this incident. It's revealed the esident #1 on 09/22/18 titted "Abuse:Abuse of Procedure" dated my person having ial mistreatment,	F 06	09					
	anuse, or neglect of	a restuent was							

STATEMENT C DEFICIENCIES	PROVIDER/SUPPLIER/CLIA COMPU							
	der or supplier Y CENTER FOR REHABILITA	FION AND HEALING		street address, city, state, zip code 1301 NORTH MONROE DRIVE XENIA OH, 45385				
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F 0609	Administrator. The A the concern to the st	ting the incident to the dministrator reported ate agency within 24 the investigation within sed on incidental during the course of	F 06	09		The second secon		
F 0610 SS=D	Alleged Violation §483.12(c) In responsible abuse, neglect, exploration investigated. §483.12(c)(2) Have alleged violations an investigated. §483.12(c)(3) Prevestigated, exploration investigated in accordance investigations to the her designated representation including to the State within 5 working day the alleged violation corrective action mutalis STANDARD is by:	citation, or citity must: evidence that all e thoroughly Int further potential citation, or he investigation is in If the results of all administrator or his or esentative and to other ce with State law, e Survey Agency, is of the incident, and if is verified appropriate	F 06	910	On 10-11-18, RNs, LPNs and STNAs we in-serviced by the Administrator on the Apolicy and Transfer/Lift policy. On 10-11-18 the Administrator was in-set by the VP of Operations on timely suspet of employees during an abuse investigated. All residents were interviewed for abuse neglect and misappropriation with no inclindings. All residents with a Bims score received a head to toe assessment on 10/11/2018 by the Don/designee with no incidental findings. The Administrator/designee will audit 1 to weekly x 4 weeks for allegations of Abus, neglect and misappropriation to ensure employees involved in an allegation of a suspended timely.	Abuse erviced ension tion. cidental < 7 x se any	11/02/2018	

Event:YCVX11

STATEMENT O		(X1) PROVIDER/SUPPLIER/CLIA 365022			(x2) multiple construction a, building b, wing	CON	YE SURVEY APLETED D/10/2018
•	ider or supplier Y CENTER FOR REHABILITA	tion and healing		1301	t address, city, state, zip code t NORTH MONROE DRIVE IA OH, 45385		
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F 0610	review, the facility fa suspend staff and co following potential m an unsafe transfer v femur fracture. This of three reviewed for identified three SRI's months. Facility cer Findings include: Review of the medic #1 revealed she was Diagnoses including	iff interview and policy illed to immediately implete staff training istreatment/neglect of which resulted in a right affected one (#1) out accidents. The facility is in the past three is was 77.	F 06	10			
	assessment dated 0 resident had severe was totally depende transfers, did not an recent falls. Review plan revealed a med initiated on 12/01/16 Review of the "Resiby the staff revealed totally dependent or transfers. Review of the progression of the progressi	nbulate and had no of the resident's care chanical lift (hoyer) was for all transfers. dent Care Card" used if the resident was a staff for hoyer ess note dated .M. revealed Licensed N) #99's was informed #1 was transferred					

365022 a. building b. wing	10/10/2018
name of provider or supplier HOSPITALITY CENTER FOR REHABILITATION AND HEALING Street address, city, state, zip code 1301 NORTH MONROF DRIVE XENIA OH, 45385	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BY THE PROPERTY OF THE APPROPRIATE OF THE APPROPRIAT	
F 0610 Continued From page 10 resident's right leg was bent backwards and she sat on her leg. The physician was notified and ordered an X-ray of the leg. The resident's daughter who was her power of attorney (POA) and Registered Nurse (RN) #97 who was the former Director of Nursing (DON) were also notified. The X ray result revealed a right distal femur fracture and the resident went to the hospital the morning of 09/23/18. Review of the employee file for State Tested Nursing Assistant (STNA) #98 revealed she was hired on 07/20/16 and was an STNA in good standing. Review of the time card for STNA #98 revealed she continued to work after the incident on 09/22/18 with 17-19 P.M. and also on 09/23/18 from 7:08 A.M. to 7:07 P.M. Review of STNA #96's statement related to the incident revealed she "picked up the resident to do a one person pivot transfer from the bed to the wheelchair and accidentally sat the resident down on top of her leg". Interview with the Administrator on 10/10/18 at 12:30 P.M. verified on 09/22/18 at 11:30 A.M. STNA #98 completed an improper transfer by heresid with Resident #1 without using the mechanical lift as required. The Administrator provided documentation that nine of the staff were provided with mechanical lift education that there should always be two staff using the hoyer lift on 09/24/18; however, the	

omb no. 0938-0391

In annu of provider or supplier HOSPITALITY CENTER FOR REPIABLILITATION AND HEALING PRINTY P	STATEMENT O		(X1) PROVIDER/SUPPLIER/CLIA 365022			a. building	_	COMPLETED 10/10/2018	
PREFIX TAG PROPERCICIONEN HOUSE BERNECESED OF TRUL FOG10 Continued From page 11 Administrator identified 18 STNA's and the licensed nursing staff that were not provided with this training. The Administrator verified the improper transfer resulting in a fermul fracture for the resident was not reported to her timely until the next day 09/23/18, STNA #98 was not suspended timely until the end of her shift on 09/23/18 at 7:07 P.M., and the nursing staff training was not completed. The Administrator verified the incident was not reported to the state agency as a Self Resported Incident (SRI) for potential mistreatment that resulted in a fracture for Resident #1 and there was no staff training related to the abuse policy following this incident. Review of the policy titled "Abuse: Abuse Reporting Policy and Procedure" dated 01/01/16 revealed any person having knowledge of potential mistreatment, abuse, or neglect of a resident was responsible for reporting the incident to the Administrator. The Administrator reported the concern to the state agency within 24 hours and results of the investigation within five days. The investigation included appropriate corrective action euch as staff training. The staff was immediately suspended during the investigation to protect resident from further harm. This deficiency is based on incidental			ation and Healing		1301	I NORTH MONROE DRIVE			
Administrator identified 18 STNA's and the licensed nursing staff that were not provided with this training. The Administrator verified the improper transfer resulting in a femur fracture for the resident was not reported to her timely until the next day 09/23/18, STNA #98 was not suspended timely until the end of her shift on 09/23/18 at 7:07 P.M., and the nursing staff training was not completed. The Administrator verified the incident was not reported to the state agency as a Self Reported Incident (SRI) for potential mistreatment that resulted in a fracture for Resident #1 and tinere was no staff training related to the abuse policy following this incident. Review of the policy titled "Abuse:Abuse Reporting Policy and Procedure" dated Un/01/16 revealed any person having knowledge of potential imistreatment, abuse, or neglect of a resident was responsible for reporting the incident to the Administrator. The Administrator reported the concern to the state agency within 24 hours and results of the investigation within five days. The investigation included appropriate corrective action such as staff training. The staff was immediately suspended during the investigation to protect resident from further harm. This deficiency is based on incidental	PREFIX	(EACH DEFICICIES	ACY MUST BEPRECEDED	PREF1)		(EACH CORRECTIVE ACTION SHOULD		COMPLETIO	
this complaint investigation.	F 0610	Administrator identi licensed nursing sta provided with this tr Administrator verific resulting in a femur was not reported to next day 09/23/18, suspended timely u on 09/23/18 at 7:07 staff training was not Administrator verific reported to the state Reported Incident (mistreatment that related to the abust incident. Review of the police Reporting Policy ar 01/01/16 revealed knowledge of poter abuse, or neglect or responsible for rep Administrator. The the concern to the hours and results of five days. The investigation of the staff was pended during protect resident from This deficiency is befindings discovered.	fied 18 STNA's and the aff that were not alning. The ad the improper transfer fracture for the resident her timely until the STNA #98 was not until the end of her shift P.M., and the nursing of completed. The ad the incident was not agency as a Self SRI) for potential esulted in a fracture for ere was no staff training a policy following this by titled "Abuse: Abuse and Procedure" dated any person having the incident to the Administrator reported state agency within 24 of the investigation within estigation included the investigation to m further harm.	F 06	.10				

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STATEMENT OF (X1) DEFICIENCIES PROVIDER/SUPPLIER/CLIA 365022		,		(x2) multiple construction a. building ১. wing	(X3) DATE S COMPL 10/1				
name of provider or supplier HOSPITALITY CENTER FOR REHABILITATION AND HEALING			street address, city, state, zip code 1301 NORTH MONROE DRIVE XENIA OH, 45385						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED BY FULL		IO PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETIO		
F 0689 SS=G	(EACH DEFICICIENCY MUST BEPRECEDED		F 06	89	On 10-11-18, RNs, LPNs and STNAs we in-serviced by the Administrator on the A policy. Transfer/Lift Policy and following plans related to providing proper care an services to the resident. On 10/11/2018 Residents were interview the administrator for abuse, neglect and misappropriation with no incidental findin residents with a bims score < 7 received head to toe assessment by the Don/desion 10/11/2018 with no incidental observation on 10/11/2018 with no incidental observation with no incidental findings. Resident #1 was assessed by the Don designee on 10/11/2018 to ensure that cand services were delivered according to plan with no incidental findings. On 10/11/2018 all residents were assess adverse outcomes by the Don designee transfers and none were observed. Audits will be conducted weekly by the Edesignee 1 x week for 4 weeks to ensure residents are care planned appropriately transfers and observation that residents being transferred with an adequate amo assistance.	buse care d by ags. All a gnee ations. care core core core core all a for are	11/02/2018		

Facility ID:OH00498

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STATEMENT OF (X1) DEFICIENCIES PROVIDER/SUPPLIER/CLIA 365022				(x2) multiple construction a. building b. wing	(X3) DATE SURVEY COMPLETED 10/10/2018					
name of provider or supplier HOSPITALITY CENTER FOR REHABILITATION AND HEALING				street address, city, state, zip code 1301 NORTH MONROE DRIVE XENIA OH, 45385						
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F 0689	Continued From p	age 13	F 06	89						
	assessment dated resident had sever was totally dependent transfers, did not a recent falls. Review plan revealed a minitiated on 12/01/Review of the "Re	imum Data Set (MDS) 09/09/18 revealed the rely impaired cognition, dent on two staff for ambulate and had no ew of the resident's care echanical lift (hoyer) was 16 for all transfers. sident Care Card" used ed the resident was on staff for hoyer								
	Practical Nurse (L that while Resider from her bed to he resident's right leg and she sat on he notified and order The resident's dat of attorney (POA) (RN) #97 who was Nursing (DON) we ray result revealer fracture and the re hospital the morni Review of the hos resident was treat narcotic (morphin fracture of the righ in a position of co	P.M. revealed Licensed (PN) #99's was informed on #1 was transferred er wheelchair, the grows bent backwards or leg. The physician was ed an X-ray of the leg. Lighter who was her power and Registered Nurse as the former Director of ere also notified. The X daright distal femures are grown to the leg of 09/23/18.		The state of the s						

form cms-2567(02-99) previous versions obsolete

centers for medicare & medicald services

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA 365022		(x2) multiple construction a. building b. wing	сом	(X3) DATE SURVEY COMPLETED 10/10/2018				
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F 0689	antianxiety (ativan) a every six hours as no narcotics including N Contin at 15 mg twice 5-325 mg one tablet needed. Observation of Resident and appears comfortable with a seconfusion. Interview with the Act 10/10/18 at 12:30 P at 11:30 A.M. STNA improper transfer by #1 without using the required. This was at that resulted in a right the resident. On 10/10/18 at 2:00 attempted to contact phone and the mailtable Review of the emptorements of the date good standings with	ency Must Bepreceded By FULL age 14 ers for a low air loss dications including an and a splint on her right leg. The surveyor due to her Administrator on P.M. verified on 09/22/18 like #98 completed and by herself with Resident the mechanical lift as an isolated accident light femur fracture for 20 P.M. the surveyor act STNA #98 on the silbox was full. bloyee file for State esistant (STNA) #98		89						
	registry. Review of file revealed evidence	STNA #98's personnel se of a competency								

Facility ID:OH00498

centers for medicare & medicaid services

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA 365022		(x2) multiple construction a. building b. wing	(X3) DATE SURVEY COMPLETED 10/10/2018					
name of provider or supplier HOSPITALITY CENTER FOR REHABILITATION AND HEALING				street address, city, state, zip code 1301 NORTH MONROE DRIVE XENIA OH, 45385						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICICIENCY MUST BEPRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETIO N			
F 0689	Continued From page 15 evaluation for the use of the mechanical lift completed dated 12/01/16 by a nurse indicating this STNA met the criteria for completing appropriate two staff transfers with residents using the mechanical lift with both STNA #98 and nurse signing off on this competency evaluation. Review of STNA #98's statement related to the incident revealed she "picked up the resident to do a one person pivot transfer from the bed to the wheelchair and accidentally sat the resident down on top of her leg". Review of the policy titled "Lifts- Sit to Stand and Passive Sling Style (hoyer)" revised 08/2014 revealed the passive swing style lift (hoyer) may be used by two staff for a resident who was unable to assist with transfers.		F 0689							
·	This deficiency subsi Number OH0010030	-								